DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445391	A. BUILDING _____ B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANCHESTER HEALTH CARE CENTER	395 INTERSTATE DRIVE MANCHESTER, TN 37355

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to complete a bladder assessment to determine if a resident was appropriate for a bladder retraining program, for two residents (#49, #61), of three residents reviewed for urinary incontinence, of thirty-four resident's reviewed. The findings included: Resident #49 was admitted to the facility on October 18, 2013, with diagnoses including Head Injury, Congestive Heart Failure, Unspecified Disorder of the Kidney and Ureter, Other Specified Retention of Urine, Mononeuritis, Altered Mental Status and Alzheimers Disease. Medical Record Review of the Quarterly Minimum Data Set (MDS) dated October 25, 2013, revealed the resident was frequently incontinent. Medical Record Review of the Quarterly MDS dated January 12, 2014, revealed the resident	F 315	**F 315** 1. Residents # 49 and 61 were assessed by a Licensed Nurse on 3/3/14 for bowel and bladder function. Both residents were candidates for scheduled timed toileting programs 2. Residents at risk for bowel and bladder decline have a potential to be affected and will be assessed by a Licensed Nurse to ensure accurate resident condition and services. 3. Licensed Nurses were re-educated by the Nurse Educator on 3/5/14 on completing bowel and bladder assessments upon admission, significant change of condition and during quarterly reviews. All new hires will be educated on this procedure during orientation 4. The DON/designee will audit residents at risk for bowel and bladder decline 5 per week times 4 weeks and then monthly for 3 months to ensure compliance. All audit findings will be submitted to the Quality Assurance Performance Improvement Committee for review and evaluation.	3/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 3-5-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 315	Continued From page 1 was always incontinent. Medical Record Review of a Clinical Assessment Report completed on February 1, 2014, revealed the resident was incontinent of bladder. Review of the facility policy for Incontinence Management revealed "...Policy: It is the policy of this facility to ensure that each resident who is incontinent of bladder is identified and assessed, given the opportunity to achieve continence or to restore as much normal bladder function as is possible...Procedure: ... (4), If incontinent, the resident's voiding pattern will be recorded for 72 hours using the Voiding Elimination Record, ...(5) Following completion of the 72 hour Voiding and Elimination Record, the remainder of the Urinary Continence Assessment will be completed..." Observation on February 20, 2014, at 1:15 p.m., revealed the resident seated in a wheelchair, in the dining room. Interview with the MDS Coordinator in the conference room, on February 20, 2014, at 3:05 p.m., confirmed the resident had not been assessed for a bladder program, and an individualized toileting program had not been developed. Resident #61 was admitted to the facility on July 1, 2013, and readmitted to the facility on January 2, 2014, with diagnoses including Congestive Heart Failure, Hypertension, Morbid Obesity, Chronic Obstructive Pulmonary Disease, and Depressive Disorder. Medical record review of the 14 day Minimum Data Set (MDS) assessment dated January 14,	F 315		3/20/14

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F 315	Continued From page 2 2014, revealed the resident was frequently incontinent of urine. Medical record review of the 30 day MDS assessment dated January 28, 2014, revealed the resident was always incontinent of urine. Medical record review revealed no bladder assessment had been completed to determine if the resident was appropriate for a bladder training program. Observation on February 20, 2014, at 2:10 p.m., revealed the resident seated in a wheelchair, in the hall. Interview on February 20, 2014, at 2:55 p.m. with Certified Nursing Assistant #1 (CNA), in the hall, confirmed the resident was taken to the bathroom every two hours or when the resident would ask to go to the bathroom. Interview on February 20, 2014, at 3:05 p.m. with the MDS Coordinator, in the conference room, confirmed no bladder assessment had been completed to determine if the resident was appropriate for a bladder training program.	F 315		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356		

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F 356	Continued From page 3 - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post nurse staffing information. The findings included: Observation and interview, on February 18, 2014, at 10:20 a.m., with the Assistant Director of Nursing, at the nursing station, confirmed the nurse staffing information was not posted.	F 356	**F 356** 1. Nursing staffing, including the total number of hours worked for Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants, was posted on 2/18/14 by Staffing Coordinator and continues to be posted daily by the staffing coordinator. 2. All residents have the potential to be affected by the cited practice. 3. The Nurse Educator reeducated the staffing coordinator, DON, and Unit Managers as to the posting requirement on 2/18/14. 4. The Administrator/designee will monitor daily the nursing staffing posting for 4 weeks and then randomly for 3 months to ensure compliance. All results of the monitoring will be submitted to the Quality Assurance Performance Improvement Committee for review and evaluation.	2/18/14 2/24/14
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides	F 364		

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F 364	Continued From page 4 food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation of the resident tray lines and staff interview, the facility dietary department failed to maintain cold food at or less than 41 degrees Fahrenheit. The findings included: Observation on February 18, 2014, at 12:04 p.m., of the resident tray line in operation in the Main Dining Room, revealed the resident's were being provided the mid-day meal. Further observation revealed the dietary staff member serving the hot food was obtaining food temperatures for the meal items served. Further observation revealed four trays, stored on an open cart, which contained individually covered sliced pieces of chocolate cream pie. Further observation revealed the chocolate cream pie was 43 degrees Fahrenheit. Interview on February 18, 2014, at 12:04 p.m., with the dietary staff member obtaining the food temperatures in the Main Dining Room, confirmed the cold food should be no more than "...40 degrees..." Fahrenheit. Observation on February 18, 2014, at 12:17 p.m., of the resident tray line in operation in the Fine Dining Room, revealed the resident's were being provided the mid-day meal. Further observation revealed the dietary staff member serving the hot	F 364	**F 364** #1. Residents who received the cream pie were assessed by a Licensed Nurse on 2/19/14 for identified complaints of effects. No ill effects were noted. #2. All residents have the potential to be affected by the cited practice. #3. The Registered Dietitian re-educated dietary staff and the CDM on 2/18/14 on acceptable food temperatures. Additional education was conducted by the Registered Dietitian and CDM to ensure staff competency in the practice. Temperature logs for food and desserts have been re-established and re-educated to the dietary staff. Weekly education will be provided by the Registered Dietitian/CDM for four weeks and then quarterly. #4. The Registered Dietitian and the CDM will audit the temperature log daily times four weeks and then random for three months to ensure compliance. The results of the audit will be reported to Quality Assurance Performance Improvement Committee for review and evaluation.	3/24/14 3/18/14

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F 364	Continued From page 5 food was obtaining food temperatures for the meal items served. Further observation revealed two trays, stored on an open cart, which contained individually covered sliced pieces of chocolate cream pie. Further observation revealed the chocolate cream pie was 65 degrees Fahrenheit. Interview on February 18, 2014, at 12:26 p.m., with the dietary staff member obtaining the food temperatures in the Fine Dining Room, confirmed the cold food should be no more than "...40 degrees..." Fahrenheit.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of the manufacturer's recommendation, and interview, the facility dietary staff failed to maintain the sanitizer level and the sanitizer emersion time in the three compartment sink as recommended by the manufacturer. The findings included:	F 371	**F 371** #1. The sanitizing dispenser for the 3 compartment sink was replaced on 2/20/14 by Ecolab. #2. All residents receiving food have the potential to be affected by the cited practice. #3. Dietary staff were re-educated on procedure of checking the solution of the 3rd compartment of a 3 compartment sink and allowing equipment to stay submerged for at least one minute, by the Registered Dietitian and the CDM on 2/18/14, 2/20/14, and 2/28/14. Signage has been implemented to prompt staff on proper quaternary and bleach solutions.	

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F 371	Continued From page 6 Observation on February 19, 2014, at 3:34 p.m., in the dietary department, revealed the three compartment sink was in operation. Further observation revealed the dietary staff member washing various utensils and a plastic pitcher. Further observation revealed the dietary staff member dip the plastic pitcher into and out of the sanitizer solution and placed the plastic pitcher on the drying shelf. Further observation revealed the Certified Dietary Manager obtained the sanitizer level of 100 parts per million for a Quaternary sanitizer product. Review of the posted manufacturer's three compartment sink instructions revealed the parts per million should be 150 to 400 for the Quaternary product and the items should be totally covered in the sanitizer solution for one minute. Interview, on February 19, 2014, at 3:40 p.m., with the dietary staff member working at the three compartment sink, and the Certified Dietary Manager, confirmed the staff member failed to emerse the pitcher for one minute in the sanitizer solution. Further interview confirmed the sanitizer solution should be 150 to 400 parts per million, and the facility failed to maintain the sanitizer level.	F 371	#4. Logs have been implemented to ensure compliance of proper solution. The practice will be monitored by the Registered Dietitian/CDM three times per week for four weeks and then monthly times three weeks. Monitoring results will be brought to the Quality Assurance Performance Improvement Committee for review and evaluation.	2/20/14 2/24/14 JMC